Poupart's ligament, and at the end of six weeks the cure was complete.—*Centralblatt f. d. Med. Wissenschaften*, June, 1871, No. 25. D. F. C.

48. *Excision of the Scapula.*—Mr. Charles Steele communicated to the Surgical Section of the British Medical Association the following case of this:—

C. B., aged 8, was admitted on April 14 into the Bristol Royal Infimary, on account of a large swelling upon the right scapula, which had been forming only six weeks, and had enlarged very rapidly during the last fortnight. The tumour covered the whole surface of the scapula except the inferior angle, and encroached over the upper border towards the clavicle; it was firmly adherent to the scapula, most prominent over the spine, and had a highly elastic and, in parts, fluctuating feeling. The child had fallen off in flesh slightly, and looked rather delicate. Mr. Steele made an exploratory incision, and removed a minute portion of the substance, which on microscopic examination showed large, almost square, cells filled with secondary cells. Extirpation of the scapula was decided upon; and, on the 18th, after making a free incision down to the bone through the tumour, to confirm diagnosis, Mr. Steele made a free elliptical incision from the upper border to the inferior angle, carefully surrounding the first incision, so as to avoid infiltration. He then slipped the inferior angle of the scapula from under the latissimus dorsi, divided the muscles attached to the posterior and anterior borders, freed the subscapularis muscle from its surroundings, divided all connections of the clavicle and humerus close to those bones, and, by very delicate dissection, cleared the projections of the tumour from their close proximity to the subclavian vessels, etc. The suprascapular, posterior scapular, and subscapular arteries, and one muscular branch, were secured. The forearm was supported across the chest, and a compress of wool applied over the excavated cavity. The tumour had evidently sprung from the bone; it covered its dorsum, infiltrated its tissue, formed a large firm projection on the venter, and had stretched the supraspinatus, infraspinatus, and subscapularis muscles as a capsule inclosing it. Recovery steadily progressed till the seventh week; the wound was then nearly healed, the child ate well, had gained in flesh, was able to be up all day and go into the garden, and looked well. Two nodules of encephaloid now recurred, and were removed entire, the intercostal muscles being cleaned in doing so. Ten days afterwards, a fresh nodule formed near the spine; and the granulating surface of the wound became so infiltrated that all hope of further removal had to be abandoned. It was some satisfaction to notice that all recurrence of disease was in the lower part and towards the spine. Mr. Steele remarked that this case showed clearly two points: first, that the operation was well borne by the system, and recovered from; and, secondly, that even before cicatrization was complete, a surprising amount of movement existed in the arm. The hand and forearm could be freely used, and the arm drawn well forwards, also extended from the side, and even drawn backwards by the latissimus dorsi muscle. This showed that, had the disease not returned, a very useful limb would have resulted.—*British Medical Journal*, August 26, 1871.

49. *Primary Excision of the Elbow-joint.*—C. F. Maunder, Surgeon to London Hospital, states (*Lancet*, May 20, 1871) that all surgeons are familiar with the operation of excision in cases of disease of the elbow-joint, but he believes that primary excision of the ends of the bone forming this articulation in cases of compound fracture opening the joint is not familiar to all surgeons as a substitute for amputation. During the ten years he has been on the surgical staff of the London Hospital, he has performed excision at least eight times. "An injury in this region of the upper extremity must," he says, "be very severe indeed to induce me to amputate the limb. The worst condition would probably be that in which a large extent of soft parts had either been carried away or been so damaged as to be beyond repair, and even then I would cut away an equivalent in bone so as to adapt the length of limb to remaining sound structures. Every attempt should be made to save a healthy hand; and it should also be borne in mind that the injury is situated at the upper and not the lower part of the forearm—a very important fact as regards the future

utility of the hand, because an equally severe injury about the wrist would, if the limb were saved, be followed by more or less gluing together of those tendons upon the integrity of which the fingers depend for their utility. In the above-mentioned examples of excision the chief vessels and nerves of the limb have been uninjured, and possibly such would be a necessary condition in excision in the majority of instances, although, perhaps, an exception might now and then arise, the alternative, amputation, being postponed for a few days in order that the absolute necessity for such a severe measure might be established. In the majority of the above cases the injury resulted from a fall upon the elbow, and in this way the more important vessels and nerves escaped unhurt; but the uniformity of the fracture was remarkable—the lower end of the humerus being often broken into two chief fragments by a T-shaped fracture, one arm of the letter passing transversely above the condyles, the other at a right angle through the articular surface. This last was doubtless caused by the sharp edge of the greater sigmoid notch of the ulna. But it should also be borne in mind, and is important, that the bones when exposed by operation were more comminuted than was expected, and consequently, had no operation been performed for the removal of the fragments, severe local and general disturbance would have resulted. I am supported in this suspicion by the fact that occasionally cases have come under my observation in which, although a compound fracture close to the elbow had occurred, yet a communication with the joint was not positively determined. In such an instance the limb has been 'put up,' but the resulting local inflammation and general disturbance have been such as now and then to lead to amputation through the arm.

"Notwithstanding the utility of the limb which follows the successful performance of this operation, it cannot be undertaken with the same freedom from risk as in chronic disease of this joint. In the latter case reaction is generally mild, and comparatively little suppuration follows; while, on the contrary, in primary cases, both local and general symptoms are severe for the first few days.

"*Operation.*—This is not easy of performance. The bones entering into the formation of the joint are so irregular in their outline, especially when comminuted, that great care and the expenditure of some time are requisite in order to isolate them, and to separate the firmly attached muscles and ligamentous structures. Consequently, excision for injury is more difficult of execution than excision for disease, in which latter the muscular and ligamentous attachments are more or less wasted and destroyed. The operation is best commenced by a longitudinal incision along the centre of the back of the elbow, extending three fingers' breadth above and below the point of the olecranon; and, if conveniently situated, the original wound may be utilized to the extent of dividing the integuments only, but no deeper structures. Hitherto, when the H or the ⊢ incision has been resorted to, the transverse or the semitransverse cut has severed those very structures—the tendinous prolongation of the triceps to the fascia of the forearm—by which (I have lately demonstrated both upon the living and the dead subject) extension by the triceps muscle may be *always* secured. The integument being thus divided, the triceps muscle just above the olecranon should be cut longitudinally. The inner portion is to be detached from the end of the olecranon, and it, with the ulnar nerve and soft parts along the inner side of the bone ends, are to be separated from the bones. The outer half of the severed muscle is not to be cut transversely, but is to be scrupulously preserved continuous with its tendinous fibres which run forward between the point of the olecranon and the external condyle of the humerus. When this structure, together with muscular fibre, is detached from the subjacent bones, a broad and thick band of tissue will have been preserved, competent hereafter to extension of the forearm. Now the olecranon, if not already broken off, should be removed. Having done this, the joint is exposed, and the abnormal relations of the fragments of bone to each other can be determined, and their several removal effected. Without this the difficulties of the operation would be greatly increased, and a large section of skin be necessary.

"I am acquainted with no operation of equal magnitude, the result of which can be, as a rule, more gratifying both to the patient and the operator. To this end both patient and surgeon require patience and perseverance. The passive movements necessary to secure a useful limb are often very trying to the sufferer, and painful, in a different sense, in their execution to the surgeon. As soon as the acute inflammatory symptoms, should they arise, have subsided, and suppuration is of small extent, pronation and supination of the hand should be performed on the injured limb by the surgeon with one hand, while with the other he holds firmly the shaft of the ulna. At a later period, where a soft union is judged, after careful manipulation, to be taken place at the elbow, flexion and extension are to be slowly but unflinchingly carried on by the hand of the surgeon, and the patient is to be encouraged in these exercises himself. In this way a most useful limb, retaining the chief movements of the healthy joint, and great strength, may be secured to the patient, as I have lately shown by the exhibition of patients to several medical societies. Of the eight cases alluded to, six occurred in hospital and two in private practice. Of these, two died—one of pyæmia, and the patient in this instance was of a most desponding temperament, having expressed a certainty of death as soon as he met with the accident, and throughout his illness; the other was also the subject of a compound fracture of the skull."

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50. *Puncture of the Intestines in Puerperal Peritonitis with Great Tympanites.*—M. **Depaul** communicated to the Surgical Society of Paris, May 3, 1871, the case of a female, æt. 22, who had been delivered April 19, 1871, and who was subsequently attacked with acute general peritonitis, vomiting, considerable tympanites, and extreme anxiety. Her condition was most alarming, and speedy death seemed imminent. On the 26th of April, M. Depaul plunged a trocar in the direction of the transverse colon, from the canula of which a jet of fetid gas escaped and also some fluid having a strong stercoraceous odour. The patient immediately experienced relief. The following day M. Depaul made another puncture above the umbilicus, with the same happy result. At the subsequent meeting of the Society (May 10th) M. Depaul announced that the patient was at that time perfectly cured.—*L'Union Médicale*, July 27 and 29, 1871.

M. **Foussagrives** communicated to the Academy of Medicine a paper in which he recommends puncture of the intestines in cases of severe tympanites. He has collected eighty-four cases in which the operation has been performed, which show that the operation is not particularly dangerous. He quotes also several cases where asphyxia was imminent from the pushing up of the diaphragm.

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51. *Injury to the Cervical Vertebræ.*—Dr. J. **Fayrer** records (*Indian Med. Gazette*, June, 1871) an interesting case of this in a girl six and a half years old, who had been suddenly lifted by her head from a bench on which she was sitting on to a table at some feet distant. At the moment she felt sharp pain and heard a snap in her neck, as of a bone going out of place. "There can be no doubt," Dr. F. says, "that in this sudden and violent transport from the bench to the table, raised by the head, some sudden rotatory movement, aided by the weight of the unsupported body, caused dislocation of the articulating process of the sixth from the seventh cervical vertebra, and probably fractured the transverse process near its junction with the body of the bone."

Dr. F. placed her under the influence of chloroform, "made a careful examination, and after continued and careful extension of the neck, with counter-extension from the shoulders, effected a change in the position of the bones, and partially returned them, as nearly as possible, to their normal position. It was not deemed prudent to use any further interference, and the child was placed in the recumbent posture, with instructions to keep her so, and support the head on either side with a pillow stuffed with sand."

In a week this little patient was well and free from pain, but a certain amount of distortion remained.

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52. *Hydrate of Chloral in Tetanus.*—Mr. C. **Macnamara** states (*The Practitioner*, Sept. 1871) that he has treated since Sept. 1, 1870, ten consecutive cases of tetanus in the Chandnie Hospital with the hydrate of chloral alone.